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SCARLET FEVER—Continued.

City.	Indicated case rate per 1,000 inhabitants.	Indicated fatality rate per 100 cases.	Cases reported.	Deaths registered.	Indicated death rate per 1,000 inhabitants.	Population July 1, 1916 (estimated by U. S. Census Bureau).
From 300,000 to 500,000 inhabitants—Con.						
Buffalo, N. Y	1.315	4.38	[1] 616	27	.058	468,558
Washington, D. C	1.456	1.13	530	6	.016	363,980
Minneapolis, Minn	1.714	2.57	623	16	.044	363,454
Jersey City, N. J	2.119	1.69	649	11	.036	306,345
Newark, N. J	2.164	.79	885	7	.017	408,894
San Francisco, Cal	2.572	.67	1,192	8	.017	463,516
Milwaukee, Wis	3.629	2.59	1,584	41	.094	463,535
From 200,000 to 300,000 inhabitants:						
Louisville, Ky	.343	....	82	....	....	238,910
Rochester, N. Y	1.076	.36	[1] 276	1	.004	256,417
Denver, Colo	1.166	....	304	....	....	260,800
Columbus, Ohio	1.219	1.91	262	5	.023	214,878
Portland, Oreg	1.327	.26	392	1	.003	295,463
St. Paul, Minn	1.395	2.32	345	8	.032	247,232
Indianapolis, Ind	1.660	2.44	451	11	.040	271,708
Providence, R. I	2.938	1.75	749	14	.055	254,960
Kansas City, Mo	3.710	6.33	1,105	70	.235	297,847
From 100,000 to 200,000 inhabitants:						
Tacoma, Wash	.293	....	33	....	....	112,770
Fort Worth, Tex	.402	....	42	....	....	104,562
San Antonio, Tex	.501	....	62	....	....	123,831
Houston, Tex	.552	....	62	....	....	112,307
Spokane, Wash	.565	1.18	85	1	.007	150,323
Birmingham, Ala	.627	1.75	114	2	.011	181,762
Fall River, Mass	.647	2.41	83	2	.016	128,366
Camden, N. J	.668	1.41	[1] 71	1	.009	106,233
Nashville, Tenn	.812	1.05	95	1	.009	117,057
Paterson, N. J	.816	2.65	113	3	.022	138,443
Trenton, N. J	.842	1.06	94	1	.009	111,593
Dallas, Tex	.883	.91	110	1	.008	124,527
Atlanta, Ga	.892	.59	170	1	.005	190,558
Lowell, Mass	.901	5.88	102	6	.053	113,245
Lawrence, Mass	.945	4.21	95	4	.040	100,560
Bridgeport, Conn	.962	3.42	117	4	.033	121,579
Scranton, Pa	.967	.70	142	1	.007	146,811
Des Moines, Iowa	.974	5.05	99	5	.049	101,598
New Bedford, Mass	1.007	1.68	119	2	.017	118,158
Hartford, Conn	1.136	.79	126	1	.009	110,900
Syracuse, N. Y	1.195	.54	186	1	.006	155,624
New Haven, Conn	1.236	2.70	185	5	.033	149,685
Richmond, Va	1.410	.90	221	2	.013	156,687
Oakland, Cal	1.415	....	281	....	....	198,604
Worcester, Mass	1.561	.78	255	2	.012	163,314
Youngstown, Ohio	1.587	3.49	172	6	.055	108,385
Albany, N. Y	1.718	....	179	....	....	104,199
Reading, Pa	2.148	3.83	235	9	.082	109,381
Springfield, Mass	2.265	1.25	240	3	.028	105,942
Lynn, Mass	2.695	1.09	276	3	.029	102,425
Salt Lake City, Utah	3.561	1.67	418	7	.060	117,399
Grand Rapids, Mich	3.718	.63	477	3	.023	128,291
Toledo, Ohio	3.962	1.05	759	8	.042	191,554
Omaha, Nebr	7,748	4.84	1,282	62	.375	165,470
Dayton, Ohio	10.698	1.03	1,361	14	.110	127,224

[1] The health officer states that cases are known not to be completely reported.

CONTROL OF POLIOMYELITIS.

MINIMUM REQUIREMENTS FOR THE CONTROL OF POLIOMYELITIS RECOMMENDED BY THE CONFERENCE OF STATE AND PROVINCIAL BOARDS OF HEALTH OF NORTH AMERICA, MAY 2 AND 3, 1917.

The Conference of State and Provincial Boards of Health of North America, held at Washington, D. C., May 2 and 3, 1917, adopted a report of the committee on measures for the control of poliomyelitis which contained the following suggestions as minimum requirements for the control of the disease:

Isolation.

Isolation is a useful measure for limiting the spread of this disease. It is often, however, without demonstrable effect, because of the general prevalence of unrecognized cases and carriers.

On account of (*a*) the numerous instances where diagnosis is not made until late, so that the patient is not isolated for several weeks after the date of onset and yet no apparent secondary cases appear;

(*b*) The fact that the longest period observed where a primary case was apparently the source of infection is only 10 days;

(*c*) Epidemiological experience, which does not justify a long period of isolation;

(*d*) The satisfactory experience in at least one city and one State with the use of a two weeks' period of isolation for all known cases of poliomyelitis over several years;

Your committee recommends:

First. That an isolation period for a patient of not less than two weeks nor more than three weeks from onset be required unless the temperature has not returned to normal in the meantime.

Second. That children of the same household in contact with a patient be restricted from places of public assembly for a period of 14 days from last date of contact, as determined by the health officer.

Third. That an adult of the household, if the patient is properly isolated, may continue his vocation, provided it does not bring him into contact with children at any time.

Disinfection.

Your committee recommends that, first, the discharges from the nose, throat, and bowels of the patient be disinfected promptly; second, the caretaker shall wash her hands with soap and hot water promptly after handling said discharges; third, the caretaker shall wash her hands similarly before leaving the room occupied by the patient; fourth, isolation shall be terminated by a thorough washing of entire body and hair of the patient; and the room shall be cleaned with soap and hot water, aired and sunned; fifth, sick-room precautions should include the usual attention to cleaning and disinfection of eating utensils, personal and bed clothing, rugs, door knobs, and other things handled by the patient or caretaker.

Precautions for Physicians and Nurses.

The committee recommends that unless a special covering and gloves be worn (*a*) the physician and nurse shall so handle the patient that discharges shall not soil their clothing, special care being taken to prevent droplet infection of the respiratory tract; (*b*) the physician and nurse shall thoroughly wash their hands before leaving the premises.

Hospitalization.

The committee approves the removal to hospitals of patients affected with poliomyelitis when proper isolation and satisfactory care for the patient can not be secured in the home; but the committee believes that during the early stage of the disease the patient needs rest in bed and that transfer to a hospital may be detrimental to his welfare.

Other Suggested Measures Designed to Control the Disease.

(*a*) The committee does not recommend the use of travel certificates, but travel and contact with children should be discouraged.

(*b*) Surveillance for persons coming from infected districts, in the opinion of your committee is not necessary, unless the person has been definitely exposed to infection.

(*c*) A most effective agency in the control of this disease is the employment of public health nurses who, in cooperation with the physician, will teach sick room precautions, the necessity for rest in bed, and the need of proper support for affected parts.

(*d*) Expert diagnosticians should be provided and the use of lumbar puncture urged.

(*e*) Food, especially such as is consumed uncooked, should be considered as a possible means of transferring the infectious agent and appropriate measures should be instituted to protect the public during an outbreak.

(*f*) Where poliomyelitis occurs in a school, your committee advises that the school be not closed, but that daily medical supervision be instituted.

(*g*) Efficient screening and the use of approved insecticides should be employed so that insects shall not have access to the patient or his excretions.

(*h*) Household pets should be excluded from the sick room.

(*i*) In the presence of poliomyelitis a search for, and a careful examination of, all ill children should be made. All children having fever should be isolated pending the diagnosis.

(*j*) Prompt reporting of all recognized or suspected cases, personally, by telegraph, or by telephone, is essential, in addition to the written report required by law.

(*k*) Weekly reports by State and Territorial health authorities should be made to the United States Public Health Service.

The membership of the committee which made the report was as follows:

F. M. Meader, Director Division of Communicable Diseases, New York State Department of Health, chairman.

William C. Woodward, Health Officer, District of Columbia.

Irving A. Watson, Secretary New Hampshire State Board of Health.

A. J. Chesley, Director Division of Preventable Diseases, Minnesota State Board of Health.

S. L. Jepson, Commissioner of Health, West Virginia.

J. P. Leake, Passed Assistant Surgeon, United States Public Health Service.

David N. Roberg, secretary Oregon State Board of Health.

MENTAL EXAMINATION OF IMMIGRANTS.

ADMINISTRATION AND LINE INSPECTION AT ELLIS ISLAND.

By E. H. MULLAN, Surgeon, United States Public Health Service.

Immigrants, not traveling in the cabin, who enter the United States at the port of New York, are first brought to Ellis Island in order to undergo an examination to determine their fitness for admission.

The average immigrant remains at Ellis Island two or three hours, during which time he undergoes an examination by the Public Health Service in order to determine his mental and physical condition, and by the Immigration Service in order to find out whether he is otherwise admissible.

Immigrants are brought from the various steamships throughout New York Harbor to Ellis Island by means of barges. As soon as they land at Ellis Island they undergo the medical inspection and examination which are conducted by the officers of the Public Health Service.

1. Line Inspection.

Upon entering the examination plant of the Public Health Service, the immigrants are guided by an attendant into the different inspection lines. These lines, separated by iron railings, are four in number at their proximal end and two in number at their distal end. Each pair of lines after extending a distance of 15 feet terminates in a single line which is perpendicular to them. The two single or distal lines are also approximately 15 feet in length.

Four medical officers who carry on the general inspection are stationed each in one of the four proximal lines, and two medical officers stand at the extreme ends of the two distal lines or just where these lines merge into two common exits.